Agency:	**107 Health Care Authority**
Decision Package Code/Title:	**ML-GB Create OFA and Add BOA Staff**
Budget Period:	**2015-17 Biennial Submittal**
Budget Level:	**ML2 – Maintenance Level**

Recommendation Summary Text

The Health Care Authority (HCA) requests $5,355,000 ($2,677,000 GF-State) and 24.0 FTEs in the 2015-17 biennium to support the HCA Board of Appeals and to build a HCA Office of Fraud and Accountability.

Package Description

Board of Appeals Staffing

The HCA Board of Appeals (BOA) is currently staffed with three Review Judges. Two of the Review Judges are physically located at the DSHS' Office Building 2, where they share two DSHS Legal Secretaries with the DSHS BOA (who also is staffed with three Review Judge FTEs). The HCA's third Review Judge is located in Cherry Street Plaza—away from the other HCA Review Judges and shared support staff. The addition of two Legal Secretary FTEs will allow the HCA to operate a fully-functioning BOA at Cherry Street Plaza without the need to share space and resources with the DSHS who has indicated a desire to end the shared space and resources agreement. The DSHS has indicated that the HCA would require two Legal Secretary FTEs to affect this transition.

In addition, federal law mandates that appeals are completed 90 days from the HCA program's receipt of the appeal until the Final Order is issued. If these appeals are not timely completed within the statutory deadline, the agency is at risk of a lawsuit, as seen in other states. There is currently a backlog at the HCA BOA of over 60 cases. An additional two FTEs will provide the infrastructure and support that the HCA BOA needs to streamline processes and procedures so that this backlog can be reduced and the risk of lawsuits against the HCA for failing to meet this statutory deadline is mitigated.

Fraud and Accountability Staffing and Legislative Request

The HCA also requests 22.0 FTEs to address the immediate need to build an Office of Fraud and Accountability (OFA) that will allow the HCA to detect and fully investigate applicant/recipient Medicaid fraud.

Under the HCA-DSHS Cooperative Agreement, investigations into client fraud are handled solely by the DSHS OFA. The OFA's responsibilities include: identifying fraud, investigating fraud, and engaging the Attorney General's Office or the applicable prosecuting attorneys to take action. The DSHS has indicated a desire to end this agreement and their role in handling all Medicaid-related client fraud investigations. The result would be that all fraud early detection activities and post-eligibility Medicaid fraud investigations would need to be handled by the HCA.

The DSHS OFA is currently compromised of approximately 48.0 FTEs—23.0 are eligibility investigators, 11.0 are criminal investigators, and the remaining 14.0 FTEs are managers/support staff. The DSHS investigators are located throughout the state of Washington in 22 different locations. This statewide presence is required to perform adequate investigations and work with local law-enforcement/local prosecutors when necessary.

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Since July 2008, the DSHS OFA has investigated approximately 3,674 criminal cases that have had a Medicaid fraud component. On average, this is roughly 612 cases per year. There are currently 700 active cases at the DSHS OFA, 660 of which are criminal fraud investigations.

In order for the HCA to detect and fully investigate applicant/recipient Medicaid fraud (including fraud early detection activities) without the assistance of the DSHS, a team of investigators and support staff numbering at least 22.0 FTEs would be necessary. These FTEs would need to take appropriate investigator training and the HCA would need to pay rent and enter into lease agreements for its outstationed investigators.

Legislation is recommended if the HCA is to operate its own fraud and accountability program.

Questions related to this request should be directed to Wendy Tang at (360) 725-0456 or at Wenfang.Tang@hca.wa.gov.

Fiscal Detail/Objects of Expenditure

	FY 2016	FY 2017	Total
1. Operating Expenditures:			
Fund 001-1 GF-State	$ 1,417,000	$ 1,260,000	$ 2,677,000
Fund 001-C GF-Federal Medicaid Title XIX	$ 1,417,000	$ 1,261,000	$ 2,678,000
Total	**$ 2,834,000**	**$ 2,521,000**	**$ 5,355,000**

	FY 2016	FY 2017	Total
2. Staffing:			
Total FTEs	24.0	24.0	24.0

	FY 2016	FY 2017	Total
3. Objects of Expenditure:			
A - Salaries And Wages	$ 1,451,000	$ 1,451,000	$ 2,902,000
B - Employee Benefits	$ 446,000	$ 446,000	$ 892,000
C - Personal Service Contracts	$ -	$ -	$ -
E - Goods And Services	$ 739,000	$ 618,000	$ 1,357,000
G - Travel	$ 6,000	$ 6,000	$ 12,000
J - Capital Outlays	$ 192,000	$ -	$ 192,000
N - Grants, Benefits & Client Services	$ -	$ -	$ -
Other (specify) -	$ -	$ -	$ -
Total	**$ 2,834,000**	**$ 2,521,000**	**$ 5,355,000**

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	FY 2016	FY 2017	Total
4. Revenue:			
Fund 001-C GF-Federal Medicaid Title XIX	$ 1,417,000	$ 1,261,000	$ 2,678,000
Total	**$ 1,417,000**	**$ 1,261,000**	**$ 2,678,000**

Narrative Justification and Impact Statement

What specific performance outcomes does the agency expect?

For the HCA Office of Fraud and Accountability

The HCA OFA will have delegated authority to conduct investigations related to allegations of applicant/recipient Medicaid fraud, including fraud early detection activities. Through the OFA, investigators coordinate with staff statewide; with county prosecutors; and with local, state, federal and international law enforcement agencies when necessary. The HCA works to maintain accurate and consistent enrollment for Medicaid beneficiaries and to ensure benefit eligibility criteria are consistently applied. Further, as a public entity, the HCA serves an instrumental role as a steward of tax payer dollars and believes it necessary to ensure that limited resources are used to connect eligible families with their necessary benefits and assistance.

Potential outcomes and results of facilitating early prevention efforts to target Medicaid fraud and investigating instances of actual applicant/recipient Medicaid fraud would be similar to those obtained from the DSHS OFA. This office would serve the purpose of detecting, investigating and prosecuting any act declared to be unlawful in the administration of the Medicaid program. By way of example: in fiscal year 2009, the DSHS OFA recovered $20.6 million through provider audit activities; saved $381 million by identifying third-party insurance responsible for medical bills; and recovered $48.7 million in client-recipient overpayment and fraud.[1] While the scope of investigations by the HCA will differ, the savings and recovery numbers from the DSHS provide valuable context on the potentially positive impact of a HCA OFA.

For the HCA Board of Appeals

The additional 2.0 FTEs will provide the infrastructure and support that the HCA BOA needs operate a fully-functioning program. Potential outcomes and results include increased efficiency resolving client issues that are on appeal and satisfying statutory requirements for the timely completion of appeal under federal law. Having an understaffed BOA would open the agency up to the risk of litigation as resulting of being out of compliance with statutory deadlines.

Performance Measure Detail

Activity Inventory

H001 HCA Administration

[1] Information obtained from http://www.dshs.wa.gov/pdf/ea/1110Fraud.pdf.

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Is this decision package essential to implement a strategy identified in the agency's strategic plan?
The mission of the HCA is to provide high quality health care for the state's most vulnerable residents. This request is essential to safeguarding the state's interests as the HCA strives to achieve its mission. As of 2011, the HCA is the single state agency for the Medicaid program. By transferring Medicaid fraud programs to the HCA, the resources requesting in this proposal shall increase efficiency, increase accountability, mitigate risk and enforce statutory authority as a the state's Medicaid single state agency.

Does this decision package provide essential support to one or more of the Governor's Results Washington priorities?
This request provides essential support to the Governor's Results WA priorities outlined in Goal 5 on effective, efficient and accountable government. This proposal also ensures resource stewardship and meets the tenants of a cost-effective government by identifying and targeting applicant/recipient Medicaid fraud. Finally, this proposal increases public trust and confidence and furthers government accountability by ensuring Medicaid client eligibility standards are met and that Medicaid dollars are being appropriately spent.

What are the other important connections or impacts related to this proposal?
For the HCA Office of Fraud and Accountability
As outlined in the current RCW that has established the DSHS OFA (RCW 74.04.12), the office serves to ensure that each citizen complaint, employee complaint, law enforcement complaint, and agency referral is assessed and, when risk of fraud or abuse is present, is fully investigated and referred for prosecution or recovery. The creation of a HCA OFA would therefore involve fields of law enforcement, public administration, and criminal investigation. The HCA OFA would conduct independent and objective investigations into allegations of fraud and abuse, make appropriate referral to law enforcement when there is substantial evidence of criminal activity, and recover overpayment whenever possible and to the greatest possible degree.[2] Stakeholders and partners include citizens, employees, law enforcement, and Medicaid beneficiaries.

For the HCA Board of Appeals
The additional two FTEs will provide the infrastructure and support that the HCA BOA needs operate a fully-functioning program. Potential outcomes and results include increased efficiency resolving issues that are on appeal and satisfying statutory requirements for the timely completion of appeals under federal law. Having an understaffed BOA would open the agency up to the risk of litigation as resulting of being out of compliance with statutory deadlines.

What alternatives were explored by the agency, and why was this alternative chosen?
For the HCA Office of Fraud and Accountability
An alternative to creating a HCA OFA is for the DSHS to retain the function of the OFA for the Medicaid program. Changes in chapter 74.04 RCW would need to be made to enhance the DSHS' scope of authority to include Medicaid and the Children's Health Insurance Program (CHIP).

[2] Background information available from http://www.dshs.wa.gov/Fraud/

For the HCA Board of Appeals

Two HCA Review Officers are currently co-located with the DSHS BOA. The HCA has explored the alternative of continuing operations as is described in the shared space and resources agreement. Maintaining current operations entails having the DSHS continue to house the HCA staff. This alternative was not considered viable to the DSHS. The HCA thus developed the proposal contained herein to address having the BOA staff located within the HCA. The DSHS indicated the two legal secretaries would be required to affect the transition and sustain a fully-functioning BOA unit.

What are the consequences of adopting this package?

Supporting this proposal demonstrates the state's commitment to resource stewardship and meets the tenants of a cost-effective government by ensuring Medicaid client eligibility standards are met and that Medicaid dollars are being appropriately spent.

What is the relationship, if any, to the state capital budget?

None

What changes would be required to existing statutes, rules, or contracts, in to implement the change?

For the HCA Office of Fraud and Accountability

There will need to be legislative changes, specifically, adding sections to chapter 74.09 RCW for the establishment and creation of the HCA OFA.

For the HCA Board of Appeals

This proposal does not require changes to existing statutes, rules or contracts in order to initiate the change.

Expenditure and Revenue Calculations and Assumptions

Revenue Calculations and Assumptions:

The HCA assumes that the funding requested will be eligible for federal Medicaid match funding equal to 50 percent of the total cost.

Expenditure Calculations and Assumptions:

Expenditures for the 2015-17 biennium are at an estimated $5,355,000, including all costs associated with salaries/wages, benefits, good and services, travel, and capital outlays.

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Which costs, savings, and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

Distinction between one-time and ongoing costs:

For the HCA Office of Fraud and Accountability

The capital costs associated with setting up workspaces for new FTEs and training are one-time costs. Salary and benefit costs, and associated with new personnel and building leases are ongoing costs.

Leasing Estimate:

Locations	Full Service	FTE	Annual Cost
Olympia	$6.64	10	$199,200
Spokane	$6.15	4	$73,800
Everett	$6.61	4	$79,320
Yakima	$6.31	4	$75,720
Total		**22**	**$428,000**

For the HCA Board of Appeals

Equipment funding for 2 FTEs is one-time, all other costs are ongoing.

Budget impacts in future biennia:

Funding for FTEs continues into future biennia. The OFA targets and prosecutes general fund waste, and strengthening the HCA's statutory position in relation to Medicaid eligibility fraud detection can result in significant program savings and recovered monies related to fraud detection services.

Maintaining a fully-functioning the BOA increases efficiency resolving issues that are on appeal, satisfies statutory requirements for the timely completion of appeals under federal law, and mitigates the risk of potential lawsuits against the HCA for failing to meet statutory deadlines.